

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028502

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4083 STATE FILE NUMBER

FILED AUG 6 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in lb 40 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		d. STREET ADDRESS (If outside, give location) 3518 Thompson	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last MARGARET H. MC DONALD			4. DATE OF DEATH Month Day Year July 20, 1963		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 26 Oct. 1890	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diet. helper		10b. KIND OF BUSINESS OR INDUSTRY Merch Hosp.		11. BIRTHPLACE (City and state or country) Chester, Ill.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME H. S. Burbes			
13b. MOTHER'S MAIDEN NAME Harriett Hathaway		14. NAME OF HUSBAND OR WIFE W. O. McDonald			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [redacted]		17. INFORMANT Address Howell McDonald, 4505 Carolane, KCN, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>
DUE TO (b) <i>Myocardial Ischemia</i>		<i>2 weeks</i>
DUE TO (c) <i>Coronary Insufficiency</i>		<i>1 year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <i>Jan 1960</i> to <i>Present</i> and last saw her alive on <i>7-19-63</i> Death occurred at <i>7:45 AM</i> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>George K. Boyd MD</i>	
22b. ADDRESS <i>5111 Independence Ave</i>		22c. DATE SIGNED <i>7-20-63</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>21 July 63</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Chester, Ill.</i>
24. FUNERAL DIRECTOR <i>Mellody-McGilley-Eylar, Main & Linwood</i>		25. DATE RECD. BY LOCAL REG. <i>7-20-63</i>	26. REGISTRAR'S SIGNATURE <i>Keith Long</i>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
George K. Boyd

BY AFFIDAVIT OF

VS 300
Rev. 4/59
1
23098
3
4 1
5 2
6
7 1
8 2
94201
10
11
12 650
13

Dr. Boyd - 5111 Indep. Ave.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Alfred Z. Dickerson

Licensed Embalmer No. 5126

P. O. Address KE 11, MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.